

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER:

0 3 — 0 1 7

2. STATE:

Indiana

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL
SECURITY ACT (MEDICAID)TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE

June 1, 2003

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

42 CFR440.120

7. FEDERAL BUDGET IMPACT:

a. FFY 2003 \$ 0b. FFY 2004 \$ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 3.1-A, Addendum Page 7

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable):

Attachment 3.1-A, Addendum Page 7

10. SUBJECT OF AMENDMENT:

denture coverage

11. GOVERNOR'S REVIEW (Check One):

- ☐
- GOVERNOR'S OFFICE REPORTED NO COMMENT
-
- ☐
- COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
-
- ☐
- NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

Melanie Bella

13. TYPED NAME:

Melanie Bella

14. TITLE:

Asst. Secretary, Medicaid Policy & Planning

15. DATE SUBMITTED:

6/3/03

16. RETURN TO:

Melanie Bella
Assistant Secretary
Office of Medicaid Policy & Planning
402 W Washington, Room W382
Indpls., IN 46204
ATTN: Tracy Brunner, State Plan Coordinator

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

6/12/03

18. DATE APPROVED:

6/10/03

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

Cheryl A. Harris

21. TYPED NAME:

Cheryl A. Harris

22. TITLE: Associate Regional Administrator
Division of Medicaid and Children's Health

23. REMARKS:

RECEIVED

JUN 12 2003

DMCH/ARA

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

b. Dentures.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

c. Prosthetic devices.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

d. Eyeglasses.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

a. Diagnostic services.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

*Description provided on attachment⁵.

TN No. ~~95-016~~ 03-017

Supersedes

TN No. ~~91-19~~ 95-016

Approval Date

9/10/03
~~9/10/95~~

Effective Date

6/1/03
~~8/1/95~~

HCFA ID: 0069P/0002P

12.a. Prescribed Drugs

Provided with limitations.

Reimbursement is available for prescribed drugs subject to the limitations set out in 405 IAC 5. The following are not covered: anorectics or any agent used to promote weight loss; topical minoxidil preparations; fertility enhancement drugs; drugs prescribed solely or primarily for cosmetic purposes. All over-the-counter and non-legend items are subject to the limitations set out in 405 IAC 5-24.

In accordance with Section 4401 of P.L. 101-508 (Omnibus Budget Reconciliation Act of 1990), Indiana Medicaid will fully participate in the manufacturer rebate program. In doing so, all applicable provisions and restrictions of the legislation, as well as that of any subsequent rules and/or regulations, will be strictly adhered to. Specifically, Indiana Medicaid will reimburse for all rebating manufacturers' (as identified to the agency by HCFA) products fully in accordance with the specifications of the legislation. The program will also adhere to all reporting requirements of the legislation.

12.b. Dentures

Provided with limitations.

Prior review and authorization by the agency is required for all dentures, partials and repairs. Reimbursement is subject to the limitations set out in 405 IAC 5.

12.c. Prosthetic devices

Provided with limitations.

Prior review and authorization by the agency is required for all basic prosthetic components and repairs. Reimbursement is subject to the limitations set out in 405 IAC 5.

12.d. Eyeglasses

Provided with limitations.

Reimbursement is available subject to the limitations set out in 405 IAC 5.

13. Other diagnostic, screening
preventive and
rehabilitative services

Provided with limitations.

13.a. Diagnostic services

Reimbursement is available subject to the limitations set out in 405 IAC 5.

TN No. 03-017

Supersedes

TN No. 00-007Approval Date SEP 10 2003Effective Date June 1, 2003